MICHIGAN ADULT HIV CONFIDENTIAL CASE REPORT

(Patients ≥ 13 years of age)
Michigan Department of Health and Human Services

STATE #:	
eHARS Entry Date:	
Aphirm Entry Date:	
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Fax Number: 313-456-1580

I.	SURV	'EILLA	NCE	USE	ONLY

I. SURVEILLANCE USE C								
Document ID MI00-		Soundex Code		Date Re	eceived at Surveillance			
Aphirm Person ID Numbe	r	Sticky Number		Document Source				
Report Status		Report Medium		Surveilla	ance Method			
☐ New ☐ Upda	ite	□ FV □ F	□т □Е	□ A	\square F \square P \square R			
II. PATIENT IDENTIFIER INFORMATION								
Patient Legal Name (Last	, First, M	iddle)	ddle)					
Address Type Residential Correct	ctional	☐ PO ☐ Temp	orary 🔲 Homel	ess 🗌	Shelter			
Current Address								
City	City County			State	Zip Code			
Phone Number		Mobile Number		Social Security Number				
Residence at Diagnosis (c Residence at HIV diag			Stage 3 (AIDS) Dia	gnosis				
Address Same as Cu	ırrent Ad	dress						
City	County		State/Country	Zip Code				
III. DEMOGRAPHIC INFO	RMATIC	N - COMPLETE	ALL FIELDS					
Case Status HIV Infection	je 3 (AIDS)	Do you suspect this is an acute (recent) infection ☐ Yes ☐ No						
Sex at Birth ☐ Male ☐ Female	Gender Male	der Identity Male						
Date of Birth		ate of Birth	Country of Birth US Unk	Birth				
Vital Status ☐ Alive ☐ Dead ☐	Unk	Death Date		State/Territory				
Marital Status ☐ Single ☐ Married	☐ Divo	orced	wed	rith Partn	er			
Race Black (African American) White Asian American Indian/Alaskan Native Hawaiian/Pl								
Ethnicity Latino/Hispanic Yes	☐ No	Unk	Arab ☐ Ye	s 🗌 No	o 🗌 Unk			
· —								

Patient Name:			Stat	e Number:				
last		first						
IV. FACILITY OF DIAGNO	SIS							
☐ Site of 1 st Positive test	for HIV	Diagnosis 🔲 Site	e of Stage 3 (AIDS) Diagnosis				
Facility Name				Phon	e Number			
Address		City	State	Zip Code				
Provider Name (Last, Firs	t)		Provider Specialt	у				
V. CURRENT PROVIDER	OF HIV	CARE Same	as Facility of Diag	gnosis				
Provider Name (Last, Firs	t)		Facility					
City	State	Zip Code	Phone Number	Medio	cal Record Number			
VI. FACILITY PROVIDING	INFOR	MATION	,	1				
Same as Facility of Dia	gnosis	Same as Curre	ent Provider of Car	re				
Date Form Completed	ng Form	g Form						
Facility Completing Form			Phone Number					
VII. PATIENT HISTORY -	COMPL	ETE ALL FIELDS	3					
Before HIV Diagnosis, pat Sex with a male				\(\tag{Y}\)	es			
Sex with a female								
			Yes No					
Transplant/transfusion/clo				ource				
,								
High risk sex (detail in cor Heterosexual sex with an		,			= =			
Heterosexual sex with a b	•	• ,			=			
Heterosexual sex with per		-			=			
Was patient perinatally inf					= =			
VIII. TREATMENT/SERVICE					n partners or			
request help from LHD)		- (' '	,	'			
Patient Informed of HIV in	fection?	Yes No	Unk					
Patient's partners will be r	otified c	of exposure and co	ounseled by					
Local Health Departme	ent [Clinical Care Pro	ovider					
IX. WOMEN ONLY								
Patient currently pregnant	If Yes, referred to		EDC (Due Da	te)				
Yes No Unk		Yes No	Unk	01.11.1.1				
Patient delivered live infar Yes No Unk	its'?	if Yes, Most Rec	ent Delivery Date	Child Name				
Delivery Hospital			City		State			
İ			1		Ī			

last		first				<u> </u>		-			
X. DOCUMENTED LAB DATA – You may add copies of lab results and fax with form.											
Type of Test At least 2 Antibody Tests must be indicated for an HIV diagnosis IA = ImmunoAssay	Collection Date	Rapid Test	Positive or Reactive	Reactive for AG	Reactive for AB	HIV 1 Ab Positive	HIV 2 Ab Positive	Indeterminate	Undifferentiated	Negative or Non-Reactive	Manufacturer
HIV-1/2 Ag/Ab Lab IA Screen (4 th Gen Screen)		N									Numerous
HIV-1/2 Ag/Ab Lab IA (5 th Gen Screen)		N									BioPlex
HIV-1/2 Ag/Ab Lab IA (4 th Gen Discriminating Screen)		N									Roche Duo
HIV-1/2 Ag/Ab Rapid IA (4 th Gen Discriminating Screen)		Υ									Abbott Determine
HIV-1/2 Ab IA (2 nd or 3 rd Gen Screen)		ΥN									
HIV-1/HIV-2 Type Differentiating IA (Confirmatory Test)		Y									Geenius or VioOne
HIV-1 Western Blot (Confirmatory Test)		N									
HIV-1 RNA/DNA Qualitative NAAT		N									Roche, Aptima
HIV-2 RNA/DNA Qualitative NAAT		N									Roche
Rapid Home Self-Testing HIV Screen		Υ									Oraquick
HIV-Syphilis Rapid Screen (Report HIV Results Only)		Υ									Chembio DPP
Last Negative Test (prior to HIV diagnosis)		ΥN									
HIV CARE TESTS											
HIV-1 RNA Assay Quantitative Viral Load Detectable Copies/mL Collection Date Undetectable											
CD4 Count at or closest to current diagnostic status											
CD4 Count cells		Perce	entage	%			Colle	ection	Date		

State Number:

Patient Name:

Patient Name:		Sta	ite Numbe	r:			
last	first						
HIV Genotype							
Laboratory			Collection	on Date			
If HIV lab tests were NOT	documented, is HIV diagn	osis confirmed by	/ a clinical	care provider			
Yes No Unk							
If Yes, provide date of doo	cumentation by care provid	ler					
XI. STAGE 3 (AIDS) OPP	ORTUNISTIC ILLNESSES	(See instructions	s for a list	of opportunistic illnesses)			
Name of Opportunistic Illr	iess		Illness Diagnosis Date				
XII. HIV TESTING AND TI	REATMENT HISTORY (TT	⁻ H)					
Date questions answered	by patient	Main Source of	the TTH Ir	nfo			
		☐ Medical Rec	ord Reviev	w 🗌 Patient Interview			
		☐ Provider Rep	ort	Other			
First Positive Test Repo							
Ever have previous positive	ve HIV test? Date of 1 st	positive HIV Test		nymous 1 st positive test?			
Yes No Unk			Y	es No Unk			
Negative Tests Reported	•						
Ever test negative?	Date of most recer test		mber of ne ore 1 st pos	egative tests in 24 months			
☐ Yes ☐ No ☐ Unk	1001	201	010 1 poc	Unk			
History of any Antiretro	viral Treatment (ARV) Us	e \square	Check He	re if No ARV Use Ever			
, ,	ARV Used	Date Began		Date of Last Use			
For HIV TX?							
For PrEP?							
For PEP?							
For Pregnant mom?							
Currently using ARV	Date of most recent use	D	ate of last	use			
☐ Yes ☐ No							
XIII. COMMENTS							
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	t of Health and Human Ser e against any individual or						
		• .		sexual orientation, partisan			
considerations, or a disab							